colleagues to be aware we did pass them late last night.

RECOGNITION OF THE ACTING MINORITY LEADER

The ACTING PRESIDENT pro tempore. The assistant Democratic leader is recognized.

Mr. REID. Mr. President, if I could say through the Chair to the leader, as the leader indicated, we have more than 30 amendments. To vote on those would take 12 hours, or something like that. The two managers last night indicated they thought two-thirds of the amendments that are pending could be accepted by the two managers.

We have on our side probably no more than six more amendments to offer on this legislation. Senator BOXER is here to offer her amendment. We have several more that could follow that. Then we have an important amendment that Senators CONRAD and LINCOLN offered. Senator LINCOLN offered it on Friday, but she withdrew it, and she wants to reoffer that today.

I think if we do not have some flareup as a result of someone wanting to change the basic components of the bill, it is very likely we can finish this bill in a reasonably short period of time. I hope the two managers, who were meeting after we adjourned last night, have been able to make headway in working through the money we have left over that has created so much interest. Anytime there are a few dollars—and this is more than a few dollars—left on the table, so to speak, there are a lot of people who are after that money. I hope that can be resolved in some fair manner. But if that is the case, then I think you, the distinguished Republican leader, can complete this bill in a reasonably short period of time.

On our side, we have done our best to have amendments ready to offer. Senator BOXER is in the Chamber. She will not take a great deal of time on her amendment. We have the other key amendments we believe are ready to be offered and can be done in a short period of time.

The ACTING PRESIDENT pro tempore. The majority leader.

Mr. FRIST. I thank the Chair. In brief response, through the Chair, I think it is a very accurate assessment of where we are. The managers continued to meet last night and will continue to meet this morning as we put together the various amendments. So I am very satisfied with the continued progress we are making and appreciate Members on both sides of the aisle coming forward with their amendments. With that, I think we will be able to stay on schedule, giving good, adequate time for debate and amendments.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Dodd) amendment No. 969, to permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and Medicare Advantage plans until 2008.

Baucus (for Dodd) amendment No. 970, to provide 50 percent cost sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare prescription drug plan, a Medicare Advantage organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

Rockefeller amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

Rockefeller amendment No. 976, to treat costs for covered drugs as incurred costs without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Akaka amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid Program and SCHIP to include citizens of the Freely Associated States.

Akaka amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Pryor amendment No. 981, to provide equal access to competitive global prescription medicine prices for American purchasers.

Bingaman amendment No. 984, to carve out from payments to Medicare+Choice and Medicare Advantage organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care.

Bingaman amendment No. 972, to provide reimbursement for federally qualified health centers participating in medicare managed care.

Bingaman amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Baucus (for Edwards) amendment No. 985, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Baucus (for Lautenberg) amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Harkin amendment No. 991, to establish a demonstration project under the Medicaid Program to encourage the provision of community-based services to individuals with disabilities.

Dayton amendment No. 957, to provide that prescription drug benefits for any Member of Congress who is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the level of prescription drug benefits passed in the 1st session of the 108th Congress.

Dayton amendment No. 960, to require a streamlining of the Medicare regulations.

Dayton amendment No. 977, to require that benefits be made available under Part D on January 1, 2004.

Baucus (for Stabenow) amendment No. 992, to clarify that the Medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the Medicaid Program.

Baucus (for Dorgan) amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare Program.

Grassley amendment No. 974, to enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs.

Durbin amendment No. 994, to deliver a meaningful benefit and lower prescription drug prices.

The ACTING PRESIDENT pro tempore. The Senator from California.

Mrs. BOXER. Mr. President, I ask unanimous consent the pending amendments be set aside.

The ACTING PRESIDENT pro tempore. Is there objection?

Hearing none, it is so ordered.

AMENDMENT NO. 1001

Mrs. BOXER. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The ACTING PRESIDENT pro tempore. The clerk will report.

The legislative clerk read as follows:

The Senator from California [Mrs. BOXER], for herself and Ms. MIKULSKI, proposes an amendment numbered 1001.

Mrs. BOXER. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap)

On page 49, strike line 3 through page 50, line 2 and insert the following:

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the annual out-of-pocket limit under paragraph (4)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a).

Mrs. BOXER. Mr. President, I offer this amendment in the true spirit of making this bill work, making it a bill that isn't confusing for our seniors, a bill that doesn't cause a hardship, as the existing bill does, for those who are the sickest.

In this amendment I have the support not only of several colleagues but of the AARP, which very strongly supports it. As you know, they have been choosing their amendments very carefully. Also we are supported by the National Committee to Preserve Social Security and Medicare. So we have both the largest senior citizen organizations backing this amendment.

I was proud to give the national Democratic radio address on Saturday. I did it on this particular issue. The issue I will be addressing through this amendment is ending the benefit shutdown that occurs in this bill just at a point in time when seniors need their benefit the most. I will explain it because it isn't that complicated once you explain it.

Let me take a step back and say the best thing about the bill before us is it starts a Medicare benefit prescription drug benefit for our seniors. We have been talking about this for years. We have been pushing it for years. Since Medicare was created 38 years ago, seniors have been waiting for a prescription drug benefit. I must say, the older I get the more I realize the revolution we have seen in medicine, one that is now one of prevention. If one takes a high blood pressure medicine, if one can't control it any other way, it becomes absolutely a lifesaving benefit. If one doesn't do that or one can't afford to do that, the chances of stroke or heart disease go up immeasurably. So the best thing about the bill before us is that it begins something so many of us have fought for so long.

Unfortunately, the plan is wanting. The plan needs to be improved. It is very complicated. I have read this from a Senator on the Republican side. I heard from a Senator on the Democratic side:

No one really understands this.

That was a reference to Senators. I have a handle on what this bill does. I have had to work; I have had my staff work. I am fortunate to have a good staff. I have talked to my colleagues. But if it took me so long to figure this out, what will it do to our people.

One of the improvements we should make is this amendment I offer. I want to explain exactly what I mean when I say a benefit shutdown. It has been called a number of things—a coverage gap, a donut hole. But a benefit shutdown really explains it because here is what happens. You are going about your business. You are paying your premium. You are getting your 50-percent benefit after you pay your deductible. And bingo, you hit a certain point and what happens? No more benefit.

I have studied 100 different plans that offer a benefit. Ninety-nine of them don't have any of this. One of them has this, but it is a very rich plan and the benefit shutdown is very small. So this is the only plan I have ever seen in existence that has this ridiculous benefit shutdown. I don't understand why it happened, but I guess the bill was a compromise so that is why we have it.

Let me explain what it means. I will show a couple of charts to you. After a senior pays $275 in a deductible, they start getting 50 percent of the cost of the drug reimbursed. So it is a 50-percent benefit, once you have paid your deductible. By the way, every month you have at least a $35 premium.

Now all of a sudden, you get to $4,500 worth of drugs and your benefit shuts down and the next $1,300 you have to pay out of your own pocket. I know the State of the Presiding Officer is not much different from mine in the sense that our seniors are mostly low income. Many of them are living on their Social Security checks, maybe a little more, but since the market went down, many of them are relying on their Social Security checks. For them to have to pay $1,300 right in the middle of a year is absolutely outrageous. That is why AARP is supporting my amendment. They sent out a letter on my amendment.

I ask unanimous consent to print the letter in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AMERICAN ASSOCIATION
OF RETIRED PERSONS,
Washington, DC, June 19, 2003.

Hon. BARBARA BOXER,
U.S. Senate,
Washington, DC.

DEAR SENATOR BOXER: AARP supports your amendment to close the coverage gap that exists in the drug benefit design of S. 1.

Throughout the debate over a Medicare prescription drug benefit, AARP has voiced our members' concerns about the need for affordable and adequate coverage. Chief among these concerns continues to be the existence of a gap in the benefit. We appreciate the efforts made by the Finance Committee to close the gap and we believe the Senate should finish the job.

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Thank you for your leadership on the issue. We look forward to working with you and other members of the Senate to enact a prescription drug benefit that will provide meaningful relief to current and future Medicare beneficiaries.

Sincerely,

WILLIAM D. NOVELLI.

Mrs. BOXER. I will read it. That is why they said I could mention on the national radio address that they support my amendment—a $1,300 cost after you hit $4,500.

Let's take the case of someone who has $7,000 a year in drug costs—and many people do. Their estimated annual premium? At least $420, maybe a little more. Their deductible? $275. They pay 50 percent of the cost of their medication, $2,113, until they get to $4,500. Now comes the benefit shutdown where they have to pay 100 percent of the cost between $4,500 and $5,812. It is actually $1,312. Then they get a good catastrophic benefit where they pay 10 percent. Look at what the senior is paying for this benefit: $4,239 out of a $7,000 bill.

The point is, because of this benefit shutdown and the huge penalty, a lot of our senior citizens would get a better drug benefit if they went to Canada and bought their drugs. This is a fact. They would be better off if they went to Canada and bought their drugs. But we can fix it today. We can end this benefit shutdown, and then the benefit will be far better.

Another way to look at the benefit shutdown is to see how unfair it is to our beneficiaries. You are paying your monthly premium every single month; $35 is what we are suggesting. But it could go up. We haven't reined in what they could charge you. Anyone who has dealt with insurance companies and HMOs knows that costs go up. Even Medicare has had to raise its costs a little bit. But by the way, because Medicare administrative costs are so low, at 3 percent, compared to these companies which could be as high as 25 percent, Medicare keeps the costs down. But under this bill, you only get Medicare if you can't get a private company. So I am telling you, we are going to have seniors maybe facing increases in their premiums. But let's give it a shot. Let's say it is only $35. It is $35 a month every single month. And guess what happens in October, if you have this kind of $500-a-month expense—just to use that as an example—you do not get that benefit for almost 3 months out of the year.

What kind of plan is this? Fortunately, it is voluntary so people have to think long and hard if it makes sense for them to do it. And I will give credit where credit is due. For our lowest income people, it may be a decent deal. But for your average recipient, to have to explain why they get no benefit for 3 months puts us in a terrible situation. It harkens back to the days when we did a catastrophic benefit and seniors took it. Then when they realized what it was, they were so angry, they were just throwing themselves on legislators' automobiles to protest. I am not kidding. This happened.

I don't want to see that happen. I want to see us do a good bill, one that is really straightforward, not confusing. So we have a real problem for our vulnerable citizens.

The last chart I am going to show is this chart because I said I would read to you from AARP's letter that they sent me. I hope colleagues will listen to what they say:

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Mr. President, that is exactly what my amendment does. Let me go through this one argument at a time.

AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit.

Well, clearly, Mr. Novelli and the AARP understand the fact that you have a barrier when you know that perhaps for 3 months, even though you are paying your premium, you get no benefit. Again, we have studied all the plans. Virtually no plan in America has a benefit shutdown. So let's make this bill better.

Let's see the next thing AARP says:

They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

Absolutely. Only in the Congress could somebody come up with this way to save money. It is ridiculous. You are penalized if you are really sick. You are penalized if you are really sick because if someone gets cancer and has to buy very expensive drugs, or a family member gets Alzheimer's and they are trying to treat the disease in a way so they can have their loved one around longer, that is when they get hit with a benefit shutdown. How unfair is that?

Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment, and thus the program's ability to spread risk.

What does that mean? It means that as seniors learn what this program is about, they may well come to the conclusion, depending on the size of their drug bill, that they are better off making a trip to Canada. They will save more than going through all the rigmarole—Senator CLINTON showed on a chart the rigmarole you have to be involved in, and because the way the bill has tried to really privatize this benefit, you are at the risk of the marketplace. The risk of the marketplace is OK when you are buying a car; it is OK if you are buying a dishwasher. You are at the risk of the marketplace. Yes, if it was a year when people held back and didn't produce a new product, OK, you are disadvantaged; OK, that is the risk. But to put seniors at the risk of the marketplace for drugs is a very bad idea indeed.

Therefore, we urge the Senate to eliminate this coverage gap.

This letter is signed by William Novelli, executive director and CEO of AARP. It is a nonpartisan organization that supports this amendment strongly. We want to close this gap. We want to stop this benefit shutdown. Again, a very graphic way to show what happens to you is to say that seniors will pay half of their annual drug cost from $276 to $4,500—that is their 50 percent benefit—and then they face a $1,300 benefit shutdown, just at the time they need their medicine the most. It makes no sense.

You know, $1,300 may not sound like a lot to some of our Senators here. We get good pay and, by the way, we have a pharmaceutical benefit in our health plan. It is a very good one. It is an excellent one. You know what. It doesn't stop when you hit a certain level. Our pharmaceutical benefit just keeps on going. It just keeps on coming, as do pharmaceutical benefits in practically all the plans in America today.

Just think about the administrative overhead to figure this one out. You are going along and, all of a sudden, this red arrow kicks in: Stop. I want to know how much it is costing us to administer this kind of deal. You can imagine, you get a note in the mail. Your benefit stops. You have paid $4,500. You go back and check your records. No, I didn't, I have only paid $4,200. You call up the administrator: You have made a mistake. Well, no, I didn't. Well, yes, you did.

How many hours will a senior who is confused and upset have to spend on the phone? How many hours will an administrator have to spend working on the details of this? Too long, I can tell you that.

This plan, as it is before us, if this amendment doesn't pass, pulls the rug out from underneath the people who are going to need the help the most. So if we are in this in order to offer a plan that people will utilize, then let's support this amendment. It is as simple as that.

Many seniors take medicines to manage chronic health problems. I discussed that at the beginning. How wonderful is it that today we can avoid horrible outcomes by taking pills that will help keep our blood pressure down, regulate our heart rate, keep our insulin in check—I could go on and on and on. Some of our seniors are cutting their pills in half because they cannot afford it. How tragic would it be if, after they think they are going to have this great benefit, they find out they could do better going up to Canada and buying the pills because maybe it comes out to 25 percent when all is said and done, when you put in the benefit shutdown, the premiums cost, and the deductible. It just may not add up. How sad it would be if, after all the hoopla we are associating with this bill, the bill itself is inadequate.

I received a letter from a constituent in San Marcos, CA. She has an annual prescription drug cost that will top $10,000. Well, she will be hit with this benefit shutdown.

Another constituent from Indio, CA, told me she has made five trips to Mexico over the last several years to purchase her prescriptions. This senior drives all day long to Mexico in order to purchase affordable heart medicine that she needs to survive, that she needs so that she can wake up every day and see her grandchildren, and take a walk, and have a quality of life. She is awaiting a benefit that will make it easy for her to go down to her corner pharmacy and say: Here is my card; I am ready to go. But this particular senior is going to be shocked to find out that if she is in the category of the benefit shutdown, it is going to cost her $1,300, plus at least $35 a month, plus a deductible.

A retired physician from Marina del Rey told me that a pill he takes for heart disease went up 600 percent—from $15 to $85. So for seniors who have to take an assortment of medicine to manage chronic diseases, the cost really starts to add up.

I have 4 million senior citizens who are part of the Medicare Program in my State. If you take the population of Delaware, that is five Delawares. That is how many senior citizens I have, and they deserve a break.

Unfortunately, this bill gives them a break, a break in coverage. Let's close that break in coverage. Let's close that gap, stop the benefit shutdown, and let's have a bill of which we all can be proud.

Again, this benefit shutdown is unheard of if we look at all the plans. It would not happen to you, Mr. President, if you have FEHBP. It will not happen to your wife, your kids, or you. It does not happen to me. I do not walk in and they say: Oh, Senator, sorry, you are in that time of the year; gee, just for these 3 months, you do not get any benefit at all. I guarantee you, if our plan did that, there would be shouting at the caucus lunches: What kind of plan do we have that we walk in, in the middle of the year, and somebody tells us we do not have coverage? We are paying our premium.

We would not stand for it.

Why are we giving a plan to the seniors we represent that is far worse than the plan we have? Because we want to give tax breaks for the wealthy few, and so we cannot afford to do this?

This is not a costly fix. CBO is telling us it is $60 billion out of a $400 billion bill. Let's figure out a way to pay for it. It is easy. I can tell you right now the administrative costs in this bill range from 15 percent to 25 percent. That is $100 billion. Why are the administrative costs so high? The private sector is doing it, not Medicare. Medicare has a 3-percent overhead. The private sector has a 10- to 20-percent overhead. Let's take the bill back and figure it out and close this benefit shutdown.

I do not want to be the Senator who stands up and votes for this with a smile on my face and then have a senior stand up and say: Senator, I walked into my pharmacy in October. I have $500-a-month drug expenses, and guess what, I have no benefit. I had to pay $1,300 out of my own pocket just when I needed the drugs the most. Why are you doing this to me? Why don't you do it to yourself?

That is what I hope they say.

I am so happy we are discussing a Medicare drug benefit, believe me. I share the views of a lot of my colleagues that it is time we have one, but to have this plan, the only plan in the country virtually that has a benefit shutdown, is an embarrassment to me. We do not have it in the Senate plan. They do not have it over in the House, I assure you of that.

We should not have a benefit that starts and stops. What is really frosting Senator GRAHAM is that seniors even have to pay a premium during this benefit shutdown. So he has an amendment—we have not voted on it yet—that says at least for October, November, and December, do not charge seniors a premium.

It is the same as if someone walked in a store and said: I want to buy a TV set, here is my money; I am going to pay it off over 3 months, here is my money. And they say, thank you very much; you are not getting a TV set; we will deliver it in 3 months. But you advertised it. No, you have to pay me 3 months, and then I will send you your TV set.

In a free market economy, this is a very sick idea. This does not make any sense. In our society, if you put money down, you pay for a benefit, you pay for a product, you get it.

I think BOB GRAHAM has a good idea: If you are going to do this to seniors, then do not make them pay their premium. At least show some regard for the person.

You are a senior; you are on several drugs; you are feeling good; the medicine really helps you; you have signed up for the plan; you have paid your deductible; you start getting your 50 percent benefit; and, boom, it is over, when you reach $4,500. Your benefit shuts down.

I cannot say it enough. It is unheard of to pay a $1,300 penalty for sickness. I cannot say it enough.

You have signed up. A few months go by, and you add the costs up in your head trying to figure out how much your medicine is costing. You realize you are going to hit the $4,500 benefit shutdown. Your doctor says you need to keep taking the medicine because you are worse, and he knows you are worried about entering the benefit shutdown. You are going to be hit with the full cost of those drugs for that period. What are you going to do?

You sit down and you crunch the numbers. You ask: How can I cut costs? You may well skip your medicine; you may well cut the pills in half; and you may well threaten your health and your life.

The benefit shutdown is wrong. It goes against everything we do in this country. Nobody else does this. It is not that expensive to fix. You are going to need a calculator every time you try to figure out what you have to save. You are going to need a good accountant.

A shutdown is going to cause trouble with the administration of this benefit. People will be calculating: Gee, Mr. THOMAS has used $3,925. Let's get him on the watchlist. Mrs. BOXER over there, she has used $4,000. Then suddenly you are cut off. You call up and you do not understand it. It is going to take hours to explain it to a senior citizen.

In closing my discussion of this amendment—and I will be asking for the yeas and nays on this amendment—the National Committee to Preserve Social Security and Medicare and the AARP, the two biggest senior citizen organizations in this country, endorse this amendment.

I am to again read from Mr. Novelli's letter because this says it all in a very clear way, and I hope my presentation has demonstrated that everything Mr. Novelli, the CEO of AARP, has stated is true:

> AARP members find the notion of a gap in coverage—

That is benefit shutdown—

> to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase. Our members do not understand why coverage would cease at a time when their drug expenses increase. The continued existence of this benefit gap threatens the workability of the benefit by jeopardizing adequate enrollment and thus the program's ability to spread risk. Therefore, we urge the Senate to eliminate this coverage gap.

Signed William Novelli, AARP.

I thank the AARP because I know they are calling colleagues and explaining this. Just remember, do unto others as you would like them to do unto you. Do my colleagues want to have their drug benefit changed so that just when they need their pharmaceutical product the most, they tell you it is not covered for you; it is not covered for your wife; it is not covered for your husband; it is not covered for your children? Mr. President, you do not want that. Why are we doing it to the seniors? At least give them a break and close down this benefit shutdown because if we do not, if we do not vote for this amendment, people are going to be at our doors because they are not going to understand it.

If my colleagues vote for this amendment and we fix this, we can truly say we have made this a far better plan, a plan more like our own, a plan more like the other 100 plans I have looked at.

I yield the floor.

I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). Is there a sufficient second? At this time, there is not a sufficient second.

Mrs. BOXER. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. BOXER. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. BOXER. I renew my request for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask that all pending amendments be temporarily laid aside so the Senator from Arkansas can offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Arkansas.

Mrs. LINCOLN. I thank the ranking member of the Finance Committee, as well as the chairman, for their diligence in this very important issue.

I say to my colleagues, I do not think we will be taking up an issue quite as critical as this one for quite some time when we reflect both on the economy of our country and the quality of life we want to provide our seniors in this Nation and, more importantly, when we think about where our Nation is going in terms of the demographics and the number of seniors we actually have in this country, going from 41 million Americans over the age of 65 to an explosion in the next 15 to 20 years of almost 70 to 75 million Americans over the age of 65.

In looking at this prescription drug package, I hope we all will look at it not only as an ability to provide the seniors the kind of quality of life we want to provide them but that we also look at it as an economic issue in terms of what it is going to cost us in this great country to provide the kind of quality of care in the next 20 years if we do not look at a prescription drug

package which is going to provide our seniors with the ability to live their lives in a way where it will be less costly to the more expensive areas of health care and, more importantly, they will be able to live the final years of their life in comfort and certainly more comfortable circumstances, hopefully at home, and have the quality of life we want them to have.

Medicare has been a successful, stable program for millions of seniors and individuals with disabilities for over 40 years. Medicare has succeeded in guaranteeing hospital coverage and physician coverage for a population which was largely uninsurable. Now we are debating adding prescription drug coverage to the Medicare Program and we should do it in a way that echoes that same stability in the program seniors enjoy.

AMENDMENT NO. 1002

Mrs. LINCOLN. Mr. President, at this time I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Arkansas [Mrs. LINCOLN], for herself, Mr. CONRAD, Mr. MILLER, and Mr. CARPER proposes an amendment numbered 1002.

Mrs. LINCOLN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow medicare beneficiaries who are enrolled in fallback plans to remain in such plans for two years by requiring the same contracting cycle for fallback plans as Medicare Prescription Drug plans)

On page 83, strike lines 1 through 7, and insert the following:

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), , as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

Mrs. LINCOLN. I am extremely proud to offer this amendment with my colleagues, Senators CONRAD and MILLER. Our amendment seeks to make the drug benefit more predictable and reliable for seniors by allowing them to remain for 2 years instead of 1 year in what we are calling the fallback plan that is outlined in S. 1. As I mentioned when I began speaking this morning, Medicare is here because over 40 years ago more than a majority of seniors in this Nation were uninsurable. We were finding that private industry was not finding this group of individuals profitable enough to actually be in the marketplace and provide them a plan. So I think it is critical, as we look at what we are trying to do today in reforming Medicare and providing a prescription drug plan, that we look at what history has shown us and that we are careful to make sure the plan we provide is going to meet the needs as well as to be fair for all seniors in this great Nation and across the demographics of our country.

Senator CONRAD and I raised this issue in the Finance Committee several weeks ago, since our States are primarily rural and have not historically been attractive to the private insurance industry. This amendment we are offering today simply requires the same 2-year contracting cycle for fallback plans as is required for the private drug-only insurance plan.

We want to make sure the private plans that can come in for a 2-year contract for our seniors who are out in rural areas, who are disproportionately low income, who are less attractive in many ways for these private entities to serve, will have the same opportunity and the same stability other regions of the Nation will have because those fallback plans will be there for the same amount of time as the private insurance industry.

In the underlying bill, Senators GRASSLEY and BAUCUS took a number of steps to encourage private drug-only insurance plans to contract with Medicare and deliver the drug benefit. They created a special transition risk corridor in the first 2 years to encourage these plans to participate, and they gave the administrator of CMS additional tools to get the plans in there. If the administrator determines that at least two plans cannot stomach accepting the minimum requirements for accepting risks described in the bill, then the administrator can reduce the amount of risk plans needed to assume. Alternatively, the administrator can increase the reinsurance percentage or the subsidies to encourage drug-only insurance plans to participate.

By doing all of these things, this bill acknowledges these plans currently do not exist in nature, as has been the statement of our current CMS administrator, and they must be enticed to come in and do the job. In other words, we have basically bent over backwards in this bill to bring private plans into this arena of Medicare prescription

drugs, particularly in areas where they traditionally have not come.

However, there is still no guarantee they will. That is why I am glad Senator GRASSLEY and Senator BAUCUS created a Medicare-guaranteed drug plan, or safety net, called the fallback. If the administrator exhausts all his options and still no two plans want to come in and deliver drugs to our elderly, then a Medicare-guaranteed plan or a fallback plan will deliver that drug benefit.

The only problem I have with the fallback is it is available for seniors for only 1 year at a time. This means if private insurers decide to test whether they want to offer the benefit in a community, seniors lose access to the fallback plan even if the new plan is significantly more expensive for them and/or more restrictive.

What does this mean in real life? Imagine this scenario in this chart. We have it on a chart so it certainly makes a lot of sense. There is an 85-year-old senior in rural Arkansas who enrolls in a fallback plan, fallback No. 1, in 2006 because there is only one private drug-only plan that is available in that area. Then in 2007, another private drug-only plan B enters the region so she must leave the fallback and enroll in one of them even if the new plans are not better for her.

She chooses private plan A. She suddenly has a different premium, a different cost sharing, a different formulary, and a different set of preferred network pharmacists. She must figure out if her drugs are going to be covered or not and where they must go to get them.

Then the next year, in 2008, private plan A leaves so she must again leave her plan. She enrolls then in plan B and gets used to the new premium, the new formulary. But then plan B departs in 2009. With no plans in the area, she enrolls in a new fallback plan with a whole new premium, a whole new formulary and pharmacy network, and it could go on and on.

I don't usually use charts, but I feel very comfortable with this chart because we have seen this happen before. We have seen it in rural areas where Medicare+Choice has come in, they have enticed our seniors, and then they have left very quickly, leaving seniors without any kind of coverage, having to go back to the traditional Medicare product. We know it can exist because we have seen it before.

What we want to do is to simply give seniors, particularly in rural areas, more stability in what we are proposing in this Medicare prescription drug plan. This is certainly a very real circumstance that could happen as the seniors move in and out—the fact that even in the fallback plans there is no standard design, so even when a fallback plan leaves and comes back 2 years later, it will still be a whole new scenario.

Both in the caring for my aging parent and my husband's aging parents, as well as my husband's grandmother who will be 106 this year—which is amazing in itself—providing them with more confusion is not where we want to go. We want to make this as simple as possible. We want to make it as easy a transition as we possibly can. Their management of multiple diseases or chronic problems is heavy enough in terms of the weight on their shoulders and their emotion. Providing them every year with the unfortunate circumstances of having to find a new formulary, find a new premium, a new pharmacist provider is absolutely not what we are trying to do.

I plead with my colleagues, I don't want to be in such a horrible position as this. I don't want to force my constituents in it either. It would be confusing to me. All we are asking of our colleagues is to give the fallback plan the same opportunity to succeed as we are giving those private plans, to make sure it will be there in a way that seniors will have some stability.

I hope our amendment can be adopted. It simply requires that 2-year contract, putting it in line with the current private sector business practices that happen in the real world. After all, that is what we are trying to do, make sure we provide a plan that is common in the real world. We use the analogies of plans that already exist—the FEHBP plan that we have as Federal employees. We look at what already exists in a traditional Medicare plan now. We want to make sure we provide as much continuity for our seniors as we possibly can.

This amendment goes a long way to ensure more consistency and stability for our seniors. This amendment improves seniors' choices by providing them the option not to bounce back and forth between plans with different benefits and premiums. It improves fairness by allowing seniors in both drug-only and fallback plans to remain in those plans for the same 2-year timeframe. It improves the stability of the benefit package by reducing the year-to-year variability in premiums, in cost sharing, in formularies, in local pharmacists.

I don't know how many questions other Members get from their seniors, but I get a ton of them. In my State offices, seniors call all the time for help with benefits and concerns about things that are not covered currently under Medicare. If you have not got it already, you can well imagine what the barrage on your staff and your offices is going to be when these seniors find themselves, particularly in rural areas, where they are flip-flopping back and forth from one plan to another every year without an understanding of what that plan actually is going to provide.

This amendment also aligns contract cycle with current business practices. The PBMs serving the private sector typically have 3- to 5-year contracts. Requiring the fallback plans to have a 2-year contract better reflects the real-world practices and increases the guarantee they will bid to serve regions where drug-only plans have failed to come. It also continues to allow seniors to enroll in drug-only plans even if a fallback plan is available for 2 years. Nothing prevents a senior from enrolling in a private drug-only plan if one is available in the region.

That goes back to one of the best arguments for this plan. That is, if the private plans are there and are working, you do not have to worry; the fallback plan is not even going to be there to begin with. It is not even going to exist if there are two competing private drug-only plans in the region. This is completely hypothetical if, in fact, the underlying premise that the private drug-only plans are going to reach out to every region of the country and they will be there offering a good benefit to all of our seniors.

The problem is we have history. We know it traditionally has not worked in our rural areas. We want to make sure our seniors get the same consideration other seniors in this great country get. It continues to give drug-only plans first bidding rights. Fallback plans only come to the regions after the CMS administrator has determined that two private drug-only plans will not be available, after he has exhausted all of these tools, of which we have given him many in order to entice these plans in there.

It has a very minimal scoring impact. This amendment buys a lot in making the system more stable but costs almost nothing. It is very reasonable in cost, and we pay for it, so there is no problem in terms of what we are talking about doing.

I am very proud to have worked on this amendment with my colleague, Senator CONRAD, who will speak about the importance of the amendment in making the drug benefit more predictable and reliable for seniors. I am pleased Senator MILLER has joined. Many other Senators I have visited are anxious to know about the policy we begin in this drug package for Medicare seniors, that we absolutely enter into what we are doing with the knowledge that legislation we work on here we understand is not a work of art, it is a work in progress; as we move through these processes to improve legislation, that we will take the time to understand small details. If we can supply the fallback the same opportunity, then we can also make sure this bill is going to be good for everybody.

We know as we move through the debate on this bill, as we move through the implementation, there will be multiple changes that will occur. It is important, as we take the time as we initially debate this issue, that we recognize all parts of our Nation are not exactly alike, that a one-size-fits-all is not going to fit every region of this Nation.

Most importantly, every senior in this great country is just as important as the other. If you are a low-income senior living in a rural part of this Nation and have worked hard your entire

life and want to retire in the same area in which you grew up and where you raised your children, you are not going to be slighted in a prescription drug package simply because of where you live or the fact you worked at a lower income job and may not have as much to retire on as other seniors across this Nation.

I hope as we move forward in this amendment and in this bill, we will recognize there are places where we can improve it. We will lead the charge, knowing that is what our job is, that is what this great deliberative body is for. It is to make the improvements along the way and to push a bill forward that, in the long term, will provide a better benefit for people across this Nation. But, most importantly, we must recognize our Nation is diverse. That is a huge part of its strength. Those of us who come from rural areas recognize that sometimes our needs are met in different ways.

I encourage my colleagues to take a look at this very simple amendment that doesn't cost much but can make up a great deal of ground in this bill in bringing parity for all seniors across this Nation.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I see my friend from North Dakota is eager to address the Senate. I will just be a few minutes on this particular amendment.

AMENDMENT NO. 1001

Mr. President, I rise to commend the Senator from California, Senator BOXER, for her amendment. I will support this amendment for the very sound reasons she has outlined here on the floor of the Senate.

Just going back very quickly, in 1965 we passed Medicare and we said to our seniors: Pay into the fund, play by the rules, and your health benefits will be attended to. Therefore, we provided the hospitalization and the physician fees. At that time, only 3 percent of all private companies provided any kind of prescription drug protection.

We have made extraordinary progress in recent years with the development of prescription drugs to tend the needs of all of our citizens and particularly the elderly. Now prescription drugs are as important as hospitalization and physician fees.

What this overall debate has generally been about, in terms of the prescription drug program, is how and when are we going to pass a prescription drug program that will be worthy of our senior citizens and do for our senior citizens what the hospitalization program and the physician programs, which are under Medicare, Part A and Part B, do for our seniors.

This particular proposal we have before the Senate now has two very important gaps. The Senator from California has pointed out one very important gap, a failure to provide services to many of our elderly. There is a second important gap and that is how we treat our retirees.

Senator BOXER has outlined the benefit gap that exists under this proposal. What we are talking about is seniors are going to be spending $1.8 trillion over the next 10 years. This bill only provides for $400 billion. It is only really about 22 percent of all that is going to be necessary for our seniors over the period of the next 10 years.

The issue before us is, first, whether seniors will be able to get the prescription drug program through their Medicare program. I believe the way this bill is constructed they will be. Second, what will the amount available to them be. Clearly, this bill is short.

What the Senator is reminding us about, with her excellent presentation, is that if the Senate itself had the will we could be providing the complete amount necessary to meet all the needs of our senior citizens. I believe that is what we should do.

We have had this debate before in the Senate under the Graham-Miller proposal last year, which I was proud to support. That would have cost close to $600 billion over a period of 8 years. The House Democrats had a different proposal that would have been, actually, close to $1 trillion. But it would have made all the difference and would have attended to the needs of our elderly people.

The Senate has made a different judgment. They have decided they were going to provide $3 trillion in tax cuts for the wealthiest individuals, and give short shrift to our seniors with a $400 billion proposal. That is what we have here in the Senate.

We have had opportunities, even while we were debating the tax proposal. A number of us offered amendments and said let's just take the reduction in the top three rates and perhaps the dividend tax reduction and, instead of going ahead with those additional deductions, use those resources and put them onto a prescription drug program.

We got 49 votes here in the Senate. We got 49 votes here. This body is evenly divided, effectively, on the concept that the Senator from California has provided. Virtually half of this Senate wants to provide the full benefits which would be included in the Boxer amendment. That is what I think needs to be done if we are going to provide a meaningful benefit to seniors.

As this chart points out and as the Senator has explained, after paying the $275 dollar deductible, for expenditures up to $4,500, we are finding 50 percent of all the expenditures effectively are paid for. Then we have the benefit gap in here, which is sometimes known as the donut hole. And then we find the expenditures for our seniors up at 90 percent in the high-cost areas.

It is this area the Senator from California is addressing. I imagine she would like, as well, to try to do something about reducing this deductible or even the premiums as well. Her amendment certainly would do that.

We are back to the real choice of what is important. Are we as a Nation going to say it is more important to have a prescription drug program worthy of its name and support the Boxer amendment? Or, are we going to fail to do that? I, as one Senator, as long as I am in the Senate, am going to continue to fight to be sure we provide the resources to do for prescription drugs what we are doing for our seniors under hospitalization and also with physician fees. I think that is what is fair. That is what is necessary. That is what we mean when we talk about having a good prescription drug program. That is what is really called for if we are going to be true to our senior citizens.

I thank the Senator for raising this issue again. It is really a question of choices. It is a question of priorities. This Senate has made a judgment, a decision previously that what we ought to do is provide tax reductions of $3 trillion, and therefore there are those who say we cannot afford to do what we should be doing for the senior citizens of this country. I regret it. It does seem to me the amendment, which says let's go ahead and pass the Boxer amendment and then we will sort through the pressures we are going to have on our budget in the future and perhaps review some of those excessive tax reductions—it seems to me that is in the Nation's interest.

This is a question of priorities. It is a question of choice. It is a question of value. The Senator from California has made what I think is a compelling case about what is needed to do the job. Mr. President, 22 percent is what this downpayment is. I consider it a downpayment. As I mentioned on all occasions, I think the downpayment is out there. I am going to do everything I can—I am sure the Senator from California is as well—to make sure there is not just a downpayment, but there is going to be a continuing effort on our part to make sure the senior citizens are going to be treated fairly.

Mrs. BOXER. Will my friend yield?

Mr. KENNEDY. I am happy to yield.

Mrs. BOXER. I want to ask a couple questions. The Senator used the term ''donut hole.'' I used the phrase ''benefit shutdown.'' It's all the same. But on the chart, between the yellow and the red, is a big white space. That means that between $4,500 and $5,800 essentially there is no benefit. This is a cost.

My friend is right. All we had to do is tighten up a little bit on what our colleagues wanted to do for the people who earn $1 million a year. It would not have taken that much. The cost of this, after the $400 billion, is $60 billion. We got that from CBO, a $60 billion cost.

My question is basically this: Does he not believe, when you really take a look at this, the administrative costs of making this work are going to be quite large? Think about the accounting that has to go into it, to track everybody's benefit. You have to do it

twice. Once between $4,500 and $5,800, and then it goes to 90 percent. I am convinced, I say to my friend, there will be some administrative savings here.

Also I would make the point that because this bill—I know he agrees with me on this—relies too much on the private sector, the administrative costs are sky high. Medicare runs a 3 percent administrative cost. The private sector runs between 15 and 25 percent. As a matter of fact, in the House bill they are saying it is a 25 percent cost of the entire bill.

So I say to my friend, this particular amendment is not that large a cost when you really look at administrative costs going in.

The reason I do not offset it, I say to my friend, is because I think our smart Senators and their smart staffs can sit down and figure out a way to pay for this thing where you can take a lot out of administration. I just wonder if my friend agrees that the complication involved here is worth removing.

Mr. KENNEDY. Well, the complication is costly. We know for a fact we spend $5,000 on health care for every man, woman, and child. We are spending $1.4 trillion a year for every man, woman, and child in America at the present time. That is even before we get into this. Forty percent out of every health care dollar is nonclinical. It is nonclinical. There is not an industry in the world that has that kind of, effectively, overhead.

If we reduce that from 40 cents to 35 cents, it would be $70 billion a year. If we took it down to 30 cents, which is not unreasonable, that would be $140 billion a year. It gives you some idea of what is in the health care system that is not really being translated into good kinds of services. And that is a very important issue and question.

I think the Senator is right, that there is a very high administrative cost generally in terms of our health care system, and there are things that can be done about it. I hope we will have the chance to address those. We have some ideas. But I must say, now the question really has to do with the questions of priorities, about how we are going to act. The fact is, we have the amount that is in the budget which is only the $400 billion, and you stretch it and stretch it, and pull it and pull it, and you get this kind of result. It isn't the kind of result that would be there if the Senator from California drafted the bill or if I drafted the bill, but this is where we are. I am going to do everything I possibly can to make sure we are going to have a complete system.

I thank the Senator.

AMENDMENT NO. 976

Mr. President, I know we are going to go to a vote at 11 o'clock. I would like to take just a minute on the amendment we are going to be voting on. As I understand it, it is the Rockefeller amendment that will be directed toward the retiree issue.

One of the great strengths of Medicare is that it is for everyone. Rich and poor alike contribute to the system. Rich and poor alike benefit from it.

At bottom, Medicare is a commitment to every senior citizen and every disabled American that we will not have two-class medicine in America. When a senior citizen enters a hospital, Medicare pays the same amount for their care whether they are a pauper and a millionaire. When a senior citizen goes to a doctor, she has the peace of mind of knowing that Medicare has the same obligation to pay for her treatment no matter what her financial circumstances and the doctor has no financial interest in rationing her care according to the contents of her bank account.

Through the Medicaid program, we do try to provide extra help for those who are poor. But the fact that Medicaid provides extra assistance for the poor does not reduce Medicare's obligation to provide equal treatment for all. Medicare always has primary payment responsibilities for the services it covers. Medicaid is always supplementary.

Medicaid provides critical help to the poor and the elderly, but it does not provide the same reliable guarantees of equal treatment that Medicare does. Under Medicaid, States have limited the number of days of hospital care they would provide or the number of doctors' visits they will support. States have placed arbitrary limits on the number of prescriptions.

This legislation sets an undesirable precedent for treatment of poor senior citizens who are eligible for both Medicare and Medicaid. For every other benefit, these senior citizens enroll in Medicare, and Medicaid supplements Medicare's coverage. But for this benefit, the bill says that the poor are excluded from Medicare. The only benefits they get are from the Medicaid program. Medicare is for all senior citizens who paid into the program during their working years not just some senior citizens. And it should stay that way.

This amendment rights this wrong. It says we will not take away the Medicare that the poor have earned by a lifetime of hard work. It deserves the support of the Members. I hope it is adopted.

The PRESIDING OFFICER. The Senator from North Dakota.

AMENDMENT NO. 1002

Mr. CONRAD. Mr. President, I rise to speak on the amendment of my colleague from Arkansas. This is an amendment we brought up in the Finance Committee.

Mr. SANTORUM. Mr. President, will the Senator from North Dakota yield for a unanimous consent request?

Mr. CONRAD. I am happy to yield.

Mr. SANTORUM. Mr. President, the managers of the bill have asked we enter a unanimous consent agreement that the time between 10:50 and 11 o'clock be equally divided on the Rockefeller amendment.

The PRESIDING OFFICER. Is there objection?

Mr. CONRAD. Mr. President, I would object to that because I don't want to be taken off my feet when I am finishing the presentation on our amendment. It is going to take me more than 2½ minutes, so I object to that.

The PRESIDING OFFICER. Objection is heard.

Mr. SANTORUM. I say to the Senator, let me know, if there is maybe 8 minutes equally divided, would you have time to do that?

Mr. CONRAD. I would be happy to do that.

Mr. SANTORUM. Mr. President, I ask unanimous consent that we have 8 minutes equally divided, starting at 10:52.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. CONRAD. Mr. President, as I stated earlier on the Senate floor, I believe the bill before us is a step in the right direction. It provides much-needed and long-awaited prescription drug assistance to Medicare beneficiaries across the Nation. I commend Senator GRASSLEY and Senator BAUCUS for putting this proposal together.

But while I support this effort, I also recognize its shortcomings. I think one of the biggest weaknesses of this bill—other than the fact that it is not the kind of full prescription drug plan that many had hoped for because there are not sufficient dollars to support such a plan—is the fact this underlying legislation has too much instability. It creates confusion.

We could have a senior being in four different plans in 4 different years. And if there is anything I think we know, it is that seniors want certainty. They want to know what they are getting. But under this plan, seniors could be bounced back and forth between different plans, depending upon how many private drug-only plans enter an area. That is the first problem. If a senior is in a fallback plan and two private plans enter the area, they will be forced to leave a plan they may like, and they have no choice in the matter.

The second problem is, every time they switch between drug-only and fallback plans, their benefits could change. This chart demonstrates that uncertainty. Premiums are uncertain. Deductibles are uncertain. The coinsurance, coverage gap, the covered drugs, and even access to local pharmacies with no extra charge—all of those things are subject to change.

The third issue is this very ability isn't just a problem that could occur when a senior goes from a drug-only plan to a so-called fallback plan. It could also happen if seniors go from one fallback plan to another.

When you add this all up, this is the type of situation a senior could face, as shown on this chart. The Senator from Arkansas earlier used this chart. It shows what could happen to a senior being in four different plans in 4 different years, with different premiums,

with different copays, with different formularies—that is, different drugs being covered—with different rules with respect to whether they can use their local pharmacy without additional cost.

All of these are subject to change from year to year. Every one of these—the premiums, the deductibles, the coinsurance, the coverage gap, the drugs that are covered—is subject to change. That is not the circumstance we want to construct for our seniors.

In one year of this benefit, only one drug-only plan enters a region. A senior enrolls in the fallback plan to get drug coverage. In 2007, another private plan enters, and the senior is compelled to leave the fallback plan. Whether they like that plan or don't like it, they are forced to leave it.

In the third year, we might see private plan A leave the program and the senior then be put in private plan B, again with different rules, with different copays, with different premiums, with a different coverage gap. And then again, if private plan B left the area, they could again be in a different fallback plan—four different plans in four different years.

I am particularly concerned that rural seniors could face the situation I just described. To date, private plans have not had much interest in coming into those areas. Only 2 percent of rural counties had two or more Medicare+Choice plans in August of 2001.

This amendment seeks to create more stability and to provide the kind of certainty our seniors want. I hope my colleagues will look upon this plan with favor.

I ask unanimous consent that a letter from the National Council on the Aging endorsing this amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL COUNCIL
ON THE AGING,
Washington, DC, June 23, 2003.

Hon. BLANCHE LINCOLN,
Dirksen Senate Office Building,
Washington, DC.

DEAR SENATOR LINCOLN: The National Council on Aging (NCOA)—the Nation's first organization formed to represent America's seniors and those who serve them—supports the amendment you are offering along with Senator Conrad to provide for a two-year contract cycle for the fallback plan in the Senate Medicare proposal.

It is clear from the prescription drug proposal being considered in the Senate that beneficiaries desperately need more stability and less confusion. We are concerned that under the structure currently proposed, vulnerable seniors could be forced to ping-pong back and forth every year from one plan to another—plans with potentially much different premiums, benefit structures, and formularies. We must do everything possible to avoid this kind of instability and confusion, which upset far too many seniors in recent years who enrolled in Medicare+Choice programs. This unfortunate experience must not be repeated.

We deeply appreciate the fact that, unlike the House bill, the Senate bill includes a failsafe mechanism to ensure that prescription drug coverage is guaranteed for every beneficiary choosing to participate.

Given the authority and flexibility in the Senate proposal to negotiate with private plans to reduce their risk in an effort to encourage their participation, we do not expect a significant number of beneficiaries to need the fallback plan. However, in those instances when it is necessary to guarantee access to drug coverage, seniors should not be disadvantaged by subjecting them to a system that could be disruptive and disturbing.

Thank you for your efforts and leadership on behalf of America's seniors. We urge Senators to support your amendment, which will further enhance the stability and fairness of the Senate Medicare proposal.

Sincerely,

JAMES FIRMAN,
President and CEO.

AMENDMENT NO. 976

The PRESIDING OFFICER. Under the previous order, there are 8 minutes of debate evenly divided on the Rockefeller amendment. Who yields time?

Mr. DODD. Mr. President, I ask to be yielded 2 minutes of the 4 minutes on the Rockefeller amendment.

The PRESIDING OFFICER. Who yields time?

Mr. ROCKEFELLER. Mr. President, I yield 3 minutes to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut is recognized for 3 minutes.

Mr. DODD. Mr. President, I thank my distinguished friend and colleague from West Virginia.

I hope the body will support this amendment. I have spoken about the bill generally and expressed my optimism about it despite the serious shortcomings I have. It is a major step in the right direction. We can enhance that by adopting what Senator ROCKEFELLER is offering us today: The ability to ensure that employers will continue to offer prescription drug coverage for their retirees.

What we don't want to do, as we move forward with this program, is to supplant existing retiree programs. That would be a great setback for us. The bill, as presently crafted, does not count payments made by the retiree benefit plan that are out-of-pocket expenditures by the individual beneficiary. This will vastly increase the amount of money an employer will have to pay in order to act as an effective supplement to the Medicare drug benefit, a so-called wraparound to Medicare. In other words, this bill would actually discourage employers from playing even that reduced role in terms of prescription drugs.

The Rockefeller amendment will address this problem so that employer contributions are counted toward an individual's out-of-pocket costs. We will offer an amendment ourselves that would add even a bit more. But this is a major amendment and a critical one. It would be a great irony indeed, as we move forward with our plan, that we end up discouraging employers from participating, as they have, in providing their retirees with the kind of protections they need. It would actually cost them more. It is very important we adopt this amendment. This is a critically important question.

Even before we got into this whole business, the benefits being provided by employers, by nonprofits, and others have been important in terms of enhancing a retiree's ability to pay for prescription drugs and not have to make the choice of food on the table or prescription drugs or to self-medicate by reducing the amount of prescription drugs they get. No one in this place wants to be a party to actually encouraging employers to step away from the very important part they already play in providing these benefits for their employees and retirees.

I thank the Senator from West Virginia. It is a very important amendment. I strongly endorse it and hope it will be adopted.

Ms. MIKULSKI. Mr. President, I rise in support of the amendment No. 976 offered by Senator ROCKEFELLER to protect retirees from losing their hard won health care benefits. I also support amendment No. 998 offered by Senator DODD to encourage employers to continue to provide retirees with health care coverage.

I have seen how a community is devastated when a company pulls the retiree health care plan out from under their feet. Last year, when Senator ROCKEFELLER and I worked on adding steel retirees to the trade adjustment assistance health care tax credit, the writing was on the wall for Bethlehem Steel. A once proud company, that was the backbone of several communities in Maryland, West Virginia, New York, and Pennsylvania had been crippled by illegal dumping of foreign steel.

Now Bethlehem Steel is no more and nearly 20,000 of their retirees and their families in Maryland, nearly 100,000 total, are left without the health care for which they worked their whole lives. We provided some relief for these retirees.

But we cannot let other retirees face the fear of losing their health care; face going bankrupt trying to afford their drugs, or face a confusing new system.

This legislation does not privatize Medicare: it does not coerce seniors to leave the Medicare they trust to get the drugs they need. Yet it does rely too heavily on private insurance companies. It should be a benefit for seniors and not a benefit for insurance companies that have let seniors down so many times before. Yet it puts the health care benefits of millions of seniors in jeopardy by creating an incentive for employers to drop retiree health care coverage.

That is why I will join my colleagues in offering amendments to strengthen the bill.

What would this amendment do?

CBO, our nonpartisan, unbiased analyst tell us that 37 percent of seniors with employer-sponsored coverage will lose that coverage if this bill is passed.

These retirees earned their retiree health care benefits. The benefit payments made on their behalf should be counted as their contributions toward the catastrophic cap. They earned their health care coverage. It is a part of their benefit package as a worker and should count just as the wages they pay for their prescription drugs count.

Why is this amendment important?

Employers want to do the right thing but are being squeezed at the bottom line. Prescription drug costs account for about 40 percent to 60 percent of employer retiree health care costs. What does that mean for U.S. employers? U.S. employers face competition from overseas where the cost of health care, including prescription drugs, is subsidized by the Government. What does this mean for U.S. retired workers? Unless this amendment is adopted, a senior could have closer to $10,000 in drug costs before they get the relief of the catastrophic cap. Unless this amendment is adopted millions of seniors could lose their retiree health care coverage.

Under some estimates, this bill would give insurance companies up to $25 billion to provide drug benefits to seniors. Yet thousands of employers already provide quality health care benefits to their retirees, benefits that include prescription drugs.

Congress should use the same test as a doctor would: Do no harm.

In passing this bill, we could decimate the ability of employers to provide health care coverage for their retirees. I think we should fix this.

In conclusion, I urge my colleagues to stand up for American businesses, stand up for America's workers, and stand up for America's seniors and support this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I hear often from many on the other side of the aisle that the Republican Party is the party of big corporations and corporate bailouts: This is a $66 billion, big corporation bailout being offered by Members on the other side of the aisle, $66 billion to corporate America that is already getting a huge benefit under this bill. We are already, by providing prescription drugs to all retirees, giving them the ability to basically back away, as has been discussed, from providing basic prescription drugs and still add on, if they want to add on additional benefits to the bottom line benefit. The cost savings already in the bill to corporations are in the billions and billions of dollars. But that is not enough. We have to give big corporate America another $66 billion so they can provide even more generous benefits to their retirees on top of the generous benefit we have in this legislation.

I find it almost incomprehensible that we are arguing that at a time when we are providing literally tens of billions of dollars—maybe even more than that—to corporate America to help relieve some of their retiree health care costs, now we have to add $66 billion more over the next 10 years to corporate America.

This is a very unwise amendment. It is a very costly amendment, $66 billion. In addition, you are seeing already that corporate America is getting out of the retiree health care business because it is very expensive. One of the reasons we are moving forward with this legislation is because of that. We have seen the percentage of retiree health plans drop from 71 percent to 44 percent just in the last 15 years. This is a trend that is ongoing. One of the reasons we are stepping in with this universal benefit is to address that issue.

To in effect provide an additional amount of money to corporations to basically help them maintain their effort in this area is a folly. It is a very costly proposal and should be, hopefully, defeated.

I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. Mr. President, the argument made by the Senator from Pennsylvania is interesting because what he is basically saying is that it is more important that corporate America not be allowed to keep one out of three of their people they currently sponsor, who are retirees who worked for them and who have been getting health benefits from them, out of the picture.

He talked about the cost to corporate America. My sort of worry is about the cost to the U.S. Government. That is what we do if we don't pass my amendment; we just dump everything on the U.S. Government.

So this amendment will make sure we do not jeopardize the drug coverage of millions of retirees, one out of every three, who already receive drug coverage from employer-sponsored plans. This amendment is going to ensure that the contributions made on the beneficiaries' behalf by their former employers count toward that beneficiary meeting the catastrophic limit. That is not now the case.

Employer-sponsored retiree health benefits are the single greatest source of coverage for retirees—the Presiding Officer understands what I am saying—the single greatest source of retiree health benefits available. In fact, 37 percent of all retirees who have corporate-sponsored plans simply lose them if this does not pass.

The PRESIDING OFFICER. Time has expired.

Mr. ROCKEFELLER. I hope we will pass my amendment. It is worse for employees. It is worse for employers. I hope my colleagues will support the amendment.

Mr. REID. Have the yeas and nays been ordered?

The PRESIDING OFFICER. That is correct.

The Senator from Pennsylvania has 1 minute 39 seconds remaining of the majority time.

Mr. SANTORUM. Mr. President, under the existing legislation, employers are allowed to continue to offer benefits to their employees. Many will. Many will change the structure of the benefit in which they offer to wrap around the existing Medicare benefit, as they do now with Medicare.

Their retiree insurance plans currently wrap around the existing Medicare plan. Future retiree plans will wrap around. Giving corporations $66 billion over the next 10 years as an incentive to give more generous benefits is nothing but a corporate giveaway and costs the taxpayers literally billions of dollars. It is an unwise transfer of Government dollars, taxpayer dollars to big corporations, that already have very generous health care plans, as well as retirement plans. It is not focused on what we should be focusing on here, which is the poorest of the poor.

Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER (Mr. ENZI). Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Nebraska (Mr. HAGEL) and the Senator from Indiana (Mr. LUGAR) are necessarily absent.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN), the Senator from Florida (Mr. GRAHAM), and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 52, nays 43, as follows:

[Rollcall Vote No. 233 Leg.]

YEAS—52

Alexander	Crapo	Miller
Allard	DeWine	Murkowski
Allen	Dole	Nickles
Baucus	Domenici	Roberts
Bennett	Ensign	Santorum
Bond	Enzi	Sessions
Breaux	Fitzgerald	Shelby
Brownback	Frist	Smith
Bunning	Graham (SC)	Snowe
Burns	Grassley	Specter
Campbell	Gregg	Stevens
Chafee	Hatch	Sununu
Chambliss	Hutchison	Talent
Cochran	Inhofe	Thomas
Coleman	Kyl	Voinovich
Collins	Lott	Warner
Cornyn	McCain	
Craig	McConnell	

NAYS—43

Akaka	Daschle	Inouye
Bayh	Dayton	Jeffords
Bingaman	Dodd	Johnson
Boxer	Dorgan	Kennedy
Byrd	Durbin	Kohl
Cantwell	Edwards	Landrieu
Carper	Feingold	Lautenberg
Clinton	Feinstein	Leahy
Conrad	Harkin	Levin
Corzine	Hollings	Lieberman

Lincoln	Pryor	Schumer
Mikulski	Reed	Stabenow
Murray	Reid	Wyden
Nelson (FL)	Rockefeller	
Nelson (NE)	Sarbanes	

NOT VOTING—5

Biden	Hagel	Lugar
Graham (FL)	Kerry	

The motion was agreed to.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote.

Mr. HATCH. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 984, AS MODIFIED

Mr. GRASSLEY. It is my understanding that the Senator from New Mexico is ready to modify his amendment. With the modification, I accept that amendment. We would not have a vote. I urge we proceed to the amendment of the Senator from New Mexico for consideration of his modification.

Mr. BUNNING. Reserving the right to object, could we at least understand what the modification is.

Mr. GRASSLEY. The Senator from New Mexico will explain that.

Mr. BINGAMAN. Mr. President, when I came to the Senate floor a few minutes ago, we were just informed by the Republican staff that CBO estimates the amendment we were planning to vote on would cost $5 billion. This is all brandnew information. It is erroneous information, but I have no way to contradict what CBO is saying.

Therefore, I send an amendment to the desk to modify my amendment to request a study by MedPAC on this issue which would come back to us within a year. At that point, we could make a determination as to whether we want to take the action I had originally been proposing. Let me explain.

I ask unanimous consent that I be allowed to modify my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 984), as modified, is as follows:

After section 404, insert the following:

SEC. 404A. MEDPAC STUDY AND REPORT REGARDING MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) (in this section referred to as ''MedPAC'') shall conduct a study to determine, with respect to additional payment amounts paid to subsection (d) hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

(1) whether such payments should be made in the same manner as payments are made with respect to graduate medical education under title XVIII and with respect to hospitals that serve a disproportionate share of low-income patients under the medicaid program; and

(2) whether to add costs attributable to uncompensated care to the formula for determining such payment amounts.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, MedPAC shall submit a report to Congress on the study conducted under subsection (a), together with such recommendations for legislation as MedPAC determines are appropriate.

Mr. BINGAMAN. Mr. President, the issue to which this study will give the answer is the question of whether disproportionate share hospitals that are the same net hospitals, that serve many of the individuals who would not have any health insurance, should continue to receive the DSH payments we have legislated they are entitled to, even after this prescription drug legislation becomes law. I strongly believe they should. My amendment was intended to ensure they receive those payments.

I fear the system we are adopting, which will move people into preferred provider organizations, will in fact reduce the payments to these disproportionate share hospitals, which I don't believe is the purpose or the intention of the Senate. That is the issue.

I urge my colleagues to support the study to give an answer as to whether that problem exists.

Mr. GRASSLEY. As I indicated, we accept that amendment, and I would like to have it adopted on a voice vote.

Mr. BAUCUS. Mr. President, it is unfortunate we did not get the score on the Senator's amendment until just recently. The chairman and I have been in constant contact. I have called several times today the CBO Director in order to get the scores in time for amendments. The good news is Senators have come to us so we are able to prioritize amendments and therefore calls to CBO are on amendments that will be sequenced so we can help them get the scores. We are trying our best to get CBO scores. The Senators can help us and help CBO get the scores by getting amendments to us early so we can sequence them.

On the other hand, it is very helpful if CBO can work as diligently as possible themselves and live up to their side of the bargain and get the scores to us. I hope we do not face this situation again where we get the score moments before an amendment is voted on, even though CBO knew this amendment was coming up; they had at least 24 hours' advance notice.

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment (No. 984), as modified, was agreed to.

Mr. GRASSLEY. We have had so many Democrat amendments that have been offered. We have reserved time for Republicans to fit in. It is my understanding that Senator SMITH of Oregon is prepared to offer an amendment from our side. I ask unanimous consent that Senator SMITH be recognized.

Mr. REID. Reserving the right to object, will there be a unanimous consent offered for sequencing votes later this afternoon?

Mr. GRASSLEY. Mr. President, in answer to the distinguished Democrat whip, there is an effort being made at the staff level to put together a series of votes. In further response, we are not prepared at this point to ask unanimous consent, but we will have such a request to make for stacking of votes and an order for votes.

Mr. REID. For the information of Senators, my understanding is that the two leaders want to have a series of votes starting at 2:25 this afternoon; is that right?

Mr. GRASSLEY. That is my understanding.

The PRESIDING OFFICER. The Senator from Oregon.

AMENDMENT NO. 962

Mr. SMITH. Mr. President, I ask unanimous consent that the pending amendment be set aside and I send an amendment to the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Oregon [Mr. SMITH], for himself and Mr. BINGAMAN, proposes an amendment numbered 962.

Mr. SMITH. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide reimbursement for Federally qualified health centers participating in medicare managed care)

At the end of title VI, insert the following:

SEC. ___. REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

''(3) in the case of services described in section 1832(a)(2)(D)—

''(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

''(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

''(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

''(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);''.

(b) CONTINUATION OF MEDICAREADVANTAGE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

''(j) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a

MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

''(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

''(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting ''1853(j),'' after ''1853(i),''.

(B) Section 1853(c)(5) is amended by striking ''subsections (a)(3)(C)(iii) and (i)'' and inserting ''subsections (a)(3)(C)(iii), (i), and (j)(1)''.

(c) ADDITIONAL MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

''(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

''(B) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).''.

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

Mr. SMITH. Mr. President, I rise today to offer this amendment that will protect the health care safety net and ensure access to quality health care for low-income Medicare beneficiaries who rely on our Nation's community health centers. I am pleased to be joined in this by my colleague from New Mexico, Senator BINGAMAN, who has been a strong advocate for the medically underserved. It is a privilege to work with him on this amendment.

This is an issue that affects the entire country, not just my State of Oregon. We all have community health centers. Health centers are the family doctor to more than 13 million people, more than 5 million of whom are uninsured, and nearly 1 million are low-income Medicare beneficiaries.

For many of these individuals, their local health center is the only accessible provider of preventive and primary health care services. While the centers receive Federal Public Health Service Act grant funds to support care for their uninsured patients, they rely on adequate payments from both Medicaid and Medicare for care provided to beneficiaries under both programs.

In 1990, Congress recognized the importance of protecting the integrity of the PHSA grant funds and required that health centers receive reasonable cost payments under the traditional Medicare Part B Program. This action on the part of Congress helped both to ensure that the health centers are reimbursed sufficiently for the provision of care to beneficiaries under the traditional Medicare program, and to protect access to health center services for the uninsured. The amendment we are proposing today simply would extend the same requirement to new Medicare Advantage Programs.

Specifically, the amendment would ensure that health centers are provided with a wraparound or supplemental payment, equal to the difference between the payments they now receive under Medicare generally and the payments they will receive from Medicare Advantage plans. This is not a new concept.

Under current Medicaid law, a health center is reimbursed by a managed care organization the equivalent of what the managed care organization pays any other provider of similar services. In turn, the State Medicaid Program provides a wraparound or supplemental payment for the difference between the managed care organization's payment and the health center's reasonable cost. The absence of a wraparound payment system in the current Medicare managed care program, Medicare+Choice, has left many health centers struggling to provide services to seniors under the program while trying to protect Federal grant funds intended to support care for the uninsured.

In 2001, health centers in my home State of Oregon lost more than $55 for each patient's office visit when they were enrolled under a Medicare managed care plan. In the same year, Oregon health centers lost almost as much revenue as they gained from the Medicare managed care patients. It is estimated this new percentage will grow even larger under the new Medicare Advantage Program. In fact, if current estimates are correct, health centers nationwide can expect to experience an average loss of $35 per office visit under the Medicare Advantage Program. Simply put, what this means is that without a wraparound payment system for health care centers contracting with Medicare Advantage plans, these centers will have no choice but to reach deep into their Federal grant funds, money that is supposed to go for care to the uninsured, in order to make up for the loss in Medicare payments. This will only serve to put further strain on health centers as well as the public safety net overall.

The President and the Congress have called upon this Nation to double the capacity of health centers and build a stronger primary care infrastructure for America's communities. America's health centers are trying to meet that challenge and still meet the health care needs of the Nation's growing uninsured.

In the last 3 years alone, health centers added more than 800,000 new uninsured patients to their roles, raising the number of uninsured Americans served by these centers to one in every eight Americans.

Our amendment would protect the vital mission of health centers to provide access to care to underserved rural and inner city communities. It would also bolster the goal of the President and the Congress to strengthen our health care safety net.

I have a letter in support of my amendment. I ask unanimous consent the letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

OREGON PRIMARY CARE ASSOCIATION,
Portland, OR, June 23, 2003.

Senator GORDON SMITH,
U.S. Senate, Russell Senate Office Building, Washington, DC.

DEAR SENATOR SMITH: On behalf of the 16 public and private, not-for-profit community health centers throughout the State of Oregon, I would like to extend our sincere gratitude for your sponsorship of the amendment to the Medicare reform bill which will implement ''wrap around'' payments for Federally Qualified Health Centers serving seniors under Medicare managed care.

As you know, Federally Qualified Health Centers (FQHCs) serve a critical role in their communities. In Oregon alone, more than 150,000 individuals rely on FQHCs for their primary health care needs each year. In the many rural areas of the state, in particular, FQHCs are often the only primary care providers available to serve Medicare, Medicaid and uninsured patients. The wrap around payments that you have proposed will ensure that FQHCs are adequately reimbursed for the cost of treating recipients of Medicare + Choice and the new Medicare Advantage program. Without adequate reimbursement for treating these Medicare managed care patients, FQHCs would be unable to continue to provide comprehensive, high-quality services to many of the seniors who rely on health centers for their care.

Senator Smith, our state is fortunate to have your leadership in Washington. Thank you again for your support and sponsorship of this measure that will significantly impact seniors and other underserved Oregonians being served by community health centers.

Sincerely,

CRAIG HOSTETLER,
Executive Director.

Mr. SMITH. Senator BINGAMAN and I are convinced that this amendment

goes a long way toward answering the concerns of health centers about how the Medicare Advantage Program will impact their ability to continue to provide high-quality health care services to their patients.

I thank my distinguished colleague from New Mexico for his efforts and his cosponsorship of this amendment and I urge all our colleagues to support it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I congratulate my colleague from Oregon for his leadership on this important issue. We have all worked on a bipartisan basis with the administration to increase our support for community health centers. We have all begun to recognize the very vital role they play in providing health care to many of our citizens throughout the country.

This amendment is absolutely crucial if we are going to ensure that the unintended effect of the legislation before us is not to drain funds away from community health centers as more and more people decide they want to sign up for these preferred provider organizations.

This is crucial legislation. It is very important we do this in the case of the Medicare prescription drug area, just as we did in the case of Medicaid.

I again compliment my colleague and I am honored to be a cosponsor of this amendment.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BYRD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. TALENT). Without objection, it is so ordered.

PREWAR INTELLIGENCE INVESTIGATION

Mr. BYRD. Mr. President, the news is just on the wires that six British troops have been killed near Basra in Iraq. Every day—every day—brings us sad tidings of American and/or Allied troops being killed in Iraq.

How much longer—how much longer, Mr. President—are our American fighting men and women going to have to remain in harm's way in a foreign land? How much longer are our National guardsmen and women and reservists going to have to be away from home?

The President announced not too long ago that major hostilities had ended. Were we told by this administration how long our military forces will be required to run these terrible risks that daily confront them in this biblical land of Mesopotamia, land between the two great rivers? I often asked the question, before the war began, What is going to be the cost? What is the plan? What is the administration's plan? What about the morning after the war ends?

No announcement has been made at this point that the war has ended, only that major hostilities no longer exist. And then there were public disagreements as to how many Americans would be needed in Iraq to bring about a safe and secure society.

I try to put myself in the place of a father or a husband of one of our military personnel in Iraq. I try to imagine the pain and the suffering on the part of those who wait—who wait—at home for the return of their loved ones.

Last fall, the White House released a national security strategy that called for an end to the doctrines of deterrence and containment that have been a hallmark of American foreign policy for more than half a century.

This new national security strategy is based upon preemptive war—something unheard of in the past experiences, practices, and policies of our Nation—preemptive war against those who might threaten our security.

Such a strategy of striking first against possible dangers is heavily reliant upon interpretation of accurate and timely intelligence. If we are going to hit first, based on perceived dangers, the perceptions had better be accurate. If our intelligence is faulty, we may launch preemptive wars against countries that do not pose a real threat against us or we may overlook countries that do pose real threats to our security, allowing us no chance to pursue diplomatic solutions to stop a crisis before it escalates to war. In either case, lives could be needlessly lost. In other words, we had better be certain that we can discern the imminent threats from the false alarms.

Just 96 days ago, as of June 24, President Bush announced that he had initiated a war to ''disarm Iraq, to free its people and to defend the world from grave danger.'' The President told the world:

> Our nation enters this conflict reluctantly—yet, our purpose is sure. The people of the United States and our friends and allies will not live at the mercy of an outlaw regime that threatens the peace with weapons of mass [destruction].

The President has since announced that major combat operations concluded on May 1. He said:

> Major combat operations in Iraq have ended. In the battle of Iraq, the United States and our allies have prevailed.

Since then, Mr. President, the United States has been recognized by the international community as the occupying power in Iraq. And yet we have not found any evidence that would confirm the officially stated reason that our country was sent to war; namely, that Iraq's weapons of mass destruction constituted a grave threat to the United States—a grave threat to the United States.

We have heard a lot about revisionist history from the White House of late in answer to those who question whether there was ever a real threat from Iraq. But it is the President who appears to me to be intent on revising history.

There is an abundance of clear and unmistakable evidence that the administration sought to portray Iraq as a direct, deadly, and imminent threat to the American people. But there is a great difference between the handpicked intelligence that was presented by the administration to Congress and the American people when compared against what we have actually discovered in Iraq. This Congress and the American people, who sent us here, are entitled to an explanation from this administration.

On January 28, 2003, President Bush said in his State of the Union Address:

> The British Government has learned that Saddam Hussein recently sought significant quantities of uranium from Africa.

Yet, according to news reports, the CIA knew this claim was false as early as March 2002. In addition, the International Atomic Energy Agency has since discredited this allegation.

On February 5, Secretary of State Colin Powell told the United Nations Security Council:

> Our conservative estimate is that Iraq today has a stockpile of between 100 and 500 tons of chemical weapons agents. That is enough to fill 16,000 battlefield rockets.

But, the truth is, to date we have not found any of this material, nor those thousands of rockets loaded with chemical weapons.

On February 8, President Bush told the Nation:

> We have sources that tell us that Saddam Hussein recently authorized Iraqi field commanders to use chemical weapons—the very weapons the dictator tells us he does not have.

Well, I say to my fellow Senators, we are all relieved that such weapons were not used, but it has not yet been explained why the Iraqi Army did not use them. Did the Iraqi Army flee their positions before chemical weapons could be used? If so, why were the weapons not left behind? Or is it that the army was never issued chemical weapons?

We need answers. We need answers to these and other such questions.

On March 16, the Sunday before the war began, in an interview with Tim Russert, Vice President CHENEY said the Iraqis want ''to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that.'' Vice President CHENEY said the Iraqis want ''to get rid of Saddam Hussein and they will welcome as liberators the United States when we come to do that.''

He added:

> . . . the vast majority of them would turn Saddam Hussein in in a minute if, in fact, they thought they could do so safely.

But, today Iraqi cities remain in disorder. Our troops are under attack as well as our allies. Our occupation government lives and works in fortified compounds, and we are still trying to determine the fate of the ousted murderous dictator.

On March 30, Secretary of Defense Donald Rumsfeld, during the height of the war, said of the search for weapons of mass destruction:

We know where they are. They're in the area around Tikrit and Baghdad and east, west, south, and north somewhat.

Well, Mr. President, Baghdad fell to our troops on April 9 and Tikrit on April 14, and the intelligence about which Secretary of Defense Rumsfeld spoke has not led us to any weapons of mass destruction. Whether or not intelligence reports were bent, stretched, or massaged to make Iraq look like an imminent threat to the United States, it is clear that the administration's rhetoric played upon the well-founded fears of the American public about future acts of terrorism. But upon close examination, many of these statements have nothing to do with intelligence because they are, at root, just sound bites based on conjecture. They are designed to prey upon public fear.

The face of Osama bin Laden morphed into that of Saddam Hussein. President Bush carefully blurred these images in his State of the Union Address. Listen to this quote from the President's State of the Union Address:

Imagine those 19 hijackers with other weapons and other plans—this time armed by Saddam Hussein. It would take one vial, one canister, one crate slipped into this country to bring a day of horror like none we have ever known.

Judging by this speech, not only is the President confusing al-Qaida and Iraq, but he also appears to give a vote of no confidence to our homeland security efforts. Isn't the White House the brains behind the Department of Homeland Security? Isn't the administration supposed to be stopping those vials, canisters, and crates from entering our country rather than trying to scare our fellow citizens half to death about them?

Not only did the administration warn about more hijackers carrying deadly chemicals, the White House even went so far as to suggest that the time it would take for U.N. inspectors to find solid smoking gun evidence of Saddam's illegal weapons would put the United States at greater risk of nuclear attack from Iraq.

National Security Adviser Condoleezza Rice was quoted as saying on September 9, 2002, by the Los Angeles Times:

We don't want the ''smoking gun'' to be a mushroom cloud.

''Threat by Iraq Grows,'' this is the headline that was in the Los Angeles Times.

Well, talk about hype. Mushroom clouds? Where is the evidence for this? Where is the evidence for that hype? There isn't any.

On September 26, 2002, just 2 weeks before Congress voted on the resolution to allow the President to invade Iraq and 6 weeks before the midterm elections, President Bush himself built the case that Iraq was plotting to attack the United States.

After meeting with members of Congress on that date, the President said:

The danger to our country is grave. The danger to our country is growing. The Iraqi regime possesses biological and chemical weapons. . . . The regime is seeking a nuclear bomb, and with fissile material, could build one within a year.

Well, these are the President's words. He said that Saddam Hussein is seeking a nuclear bomb. Have we found any evidence to date of this chilling allegation? No.

But President Bush continued on that autumn day:

The dangers we face will only worsen from month to month and from year to year. To ignore these threats is to encourage them. And when they have fully materialized, it may be too late to protect ourselves and our friends and our allies. By then, the Iraqi dictator would have the means to terrorize and dominate the region. Each passing day could be the one on which the Iraqi regime gives anthrax or VX—nerve gas—or some day a nuclear weapon to a terrorist ally.

Yet, 7 weeks after declaring victory in the war against Iraq, we have seen nary a shred of evidence to support the President's claims of grave, dangerous chemical weapons, links to al-Qaida, or nuclear weapons.

Just days before a vote on a resolution that handed the President unprecedented war powers, President Bush stepped up the scare tactics. On October 7, just 4 days before the October vote in the Senate on the war resolution, the President had this to say:

We know that Iraq and the al-Qaida terrorist network share a common enemy—the United States of America. We know that Iraq and al-Qaida have had high-level contacts that go back a decade.

He continued:

We've learned that Iraq has trained al-Qaida members in bomb-making and poisons and deadly gases. . . . Alliance with terrorists could allow the Iraqi regime to attack America without leaving any fingerprints.

President Bush also elaborated on claims of Iraq's nuclear program when he said:

The evidence indicates that Iraq is reconstituting its nuclear weapons program. Saddam Hussein has held numerous meetings with Iraqi nuclear scientists, a group he calls his ''nuclear mujahideen''—his nuclear holy warriors. . . . If the Iraqi regime is able to produce, buy, or steal an amount of highly enriched uranium a little larger than a single softball, he could have a nuclear weapon in less than a year.

Wasn't that enough to keep you awake, Senators? This is the kind of pumped-up intelligence and outrageous rhetoric that was given to the American people to justify a war with Iraq. This is the same kind of hyped evidence that was given to Congress to sway its vote for war on October 11, 2002.

We hear some voices saying, well, why should we care? After all, the United States won the war, didn't it? Saddam Hussein is no more. Iraq is no longer a threat. He is either dead or on the run, so what does it matter if reality does not reveal the same grim picture that was so carefully painted before the war. So what. So what if the menacing characterizations that conjured up visions of mushroom clouds and American cities threatened with deadly germs and chemicals were overdone. So what.

Our sons and daughters who serve in uniform answered the call to duty. They were sent to the hot sands of the Middle East to fight in a war that has already cost the lives of 194 Americans to this moment, thousands of innocent civilians, and unknown numbers of Iraqi soldiers. Our troops are still at risk. Hardly a day goes by that there is not another attack on the troops who are trying to restore order to a country teetering on the brink of anarchy. When are they coming home?

The President told the American people we were compelled to go to war to secure our country from a grave threat. Are we any safer today than we were on March 18, 2003? Our Nation has been committed to rebuilding a country ravaged by war and tyranny, and the cost of that task is being paid for in blood and in treasure every day.

It is in the compelling national interest to examine what we were told about the threat from Iraq. This is not revisionist history. These words are plain English words that I have quoted. It is in the compelling national interest to know if the intelligence was faulty. It is in the compelling national interest to know if the intelligence was distorted. It is in the national interest to know if the intelligence was manipulated.

Mr. President, Congress must face this issue squarely. Congress should begin immediately an investigation into the intelligence that was presented to the American people about the prewar estimates of Saddam's weapons of mass destruction and the way in which that intelligence might have been misused. This is no time for a timid, tippy-toe Congress. Congress has a responsibility to act in the national interest and to protect the American people, and we must get to the bottom of this matter.

Although some timorous steps have been taken in the past few days to begin a review of this intelligence—I must watch my words carefully, for I may be tempted to use the word ''investigation'' or ''inquiry'' to describe this review, and those are terms which I am told are not supposed to be used—the proposed measures appear to fall short of what the situation requires. We are already shading our terms about how to describe the proposed review of intelligence: cherry-picking words to give the American people the impression that the Government is fully in control of the situation, and that there is no reason to ask tough questions. This is the same problem that got us into this controversy about slanted intelligence reports. Word games, lots and lots of word games.

This is no game. For the first time in our history, the United States has gone to war because of intelligence reports claiming that a country posed a threat to our Nation. Congress should not be content to use standard operating procedures to look into this extraordinary matter.

We should accept no substitute for a full, bipartisan investigation by Congress into the issue of our prewar intelligence on the threat from Iraq and the use of that intelligence.

The purpose of such an investigation is not to play preelection year politics, nor is it to engage in what some might call ''revisionist history.'' Rather, it is to get at the truth. The longer questions are allowed to fester about what our intelligence knew about Iraq, and when our intelligence knew it, the greater the risk that American people, whom we are elected to serve, will lose confidence in our Government.

This looming crisis of trust is not limited to the public. Many of my colleagues were willing to trust the administration and vote to authorize war against Iraq. Many Members of this body trusted so much that they gave the President sweeping authority to commence war. As President Reagan famously said, ''Trust, but verify.'' Despite my opposition, the Senate voted to blindly trust the President with unprecedented—unprecedented, unprecedented—power to declare war. Shame. While the reconstruction continues, so do the questions, and it is time to verify.

I have served the people of West Virginia in Congress for half a century. I have witnessed deceit and scandal, coverup and aftermath. I have seen from both parties Presidents who once enjoyed great popularity among the people leave office in disgrace because they misled the American people. I say to this administration: Do not circle the wagons. Do not discourage the seeking of truth in these matters.

The American people have questions that need to be answered about why we went to war with Iraq. To attempt to deny the relevance of these questions is to trivialize the people's trust and confidence.

The business of intelligence is secretive by necessity, but our Government is open by design. We must be straight with the American people. Congress has the obligation to investigate the use of intelligence information by the administration in the open so that the American people can see that those who exercise power, especially the awesome power of preemptive war, must be held accountable. We must not go down the road of coverup. That is the road to ruin.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the pending amendments be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1004

Mrs. HUTCHISON. Mr. President, I ask that amendment No. 1004, which is at the desk, be called up.

The PRESIDING OFFICER. The clerk will report the amendment.

The bill clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON] proposes an amendment numbered 1004.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the medicare program at 6.5 percent)

At the end of subtitle A of title IV, add the following:

SEC. ___. FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii)(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by striking ''and'' at the end; and

(2) by striking subclause (VII) and inserting the following new subclauses:

''(VII) during fiscal years 2003, 2004, 2005, 2006, 2007, and 2008, 'c' is equal to 1.35; and

''(VIII) on or after October 1, 2008, 'c' is equal to 1.6.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

Mrs. HUTCHISON. Mr. President, today I rise, along with Senators KENNEDY, TALENT, BIDEN, KERRY, MURRAY, REED, SPECTER, BOND, CLINTON, FEINSTEIN, and DURBIN to offer an amendment for America's teaching hospitals.

The teaching hospitals in our country perform a vital role in training the doctors and nurses who conduct medical research and provide care to the needy. But the foundation of this essential public service is beginning to crack under the strain of Medicare reductions and a range of other financial pressures.

As my colleagues are aware, the Balanced Budget Act of 1997 made cuts to indirect medical education, called IME, which is an add-on for Medicare reimbursements to teaching hospitals. The add-on was reduced from 7.7 percent in 1997 to 6.5 percent in 1999. Further reductions were scheduled beginning in 2000, but those cuts were delayed until last October, and now the reimbursement rate has been dropped from 6.5 percent to 5.5 percent. That 1 percentage point means our Nation's teaching hospitals will lose almost $800 million this year, $4.2 billion over the next 5 years.

My amendment restores the reimbursement rate to 6.5 percent in fiscal year 2009. By putting this off until fiscal year 2009, of course, we are avoiding any Budget Act point of order.

There are 1,100 teaching hospitals in our country where Americans receive world-class care. Every State has at least one, so every Senator will have affected constituents. Teaching hospitals train nearly 100,000 doctors every year, and chances are, Mr. President, your physician and mine were trained at teaching hospitals.

In 1983, the Federal Government recognized that teaching hospitals cost more than their nonteaching counterparts because they incur costs to train our health care providers of the future. They provide clinical research in new procedures, technology, and treatments. Perhaps most importantly, they ensure a steady stream of high-quality physicians who are equipped to meet the health care challenges of the 21st century. They are also a major provider of indigent care in the United States. But education and training costs extra money.

The Government added the IME payment to encourage teaching hospitals to invest in our future, but, unfortunately, we have chipped away from 11.6 percent in 1983 to today's rate of 5.5 percent, which is a factor based on a hospital's resident-to-bed ratio included in Medicare reimbursement. We cannot continue to decimate funding at these hospitals that educate our medical students and expect quality medical care in the 21st century.

Teaching hospitals in Texas have lost $26.8 million in reimbursements in 2003 alone. Our State is not the hardest hit. New York lost $141 million; Pennsylvania, $78 million; and Michigan, $50 million.

One example in my State exemplifies what is happening in every teaching hospital in our country. Methodist Hospital in Houston trains more than 200 residents a year and works closely with Baylor College of Medicine to effectively train physicians in radiology, cardiology, and neurology with the newest technology. Methodist purchased an MRI machine for $4.5 million. That MRI will not only provide preventive medicine to help diagnose illnesses sooner, it also teaches the next generation of health care professionals what they cannot learn in the classroom.

This week, as we debate Medicare reform, it is imperative to reaffirm our commitment to America's teaching hospitals as these hospitals are in financial distress. If we do not restore funding, not only will they suffer, so will our health care system, particularly patient care.

I ask for the support for this amendment. I ask for the yeas and nays. I will ask for unanimous consent to stack the next two votes, but I also ask unanimous consent the vote on my amendment be in the next series of votes.

Mr. REID. Reserving the right to object, it is my understanding the Senator has asked that following the Dodd vote we vote on Pryor and Boxer.

Mrs. HUTCHISON. I was going to offer that unanimous consent.

Mr. REID. Did you ask unanimous consent on something else?

Mrs. HUTCHISON. I was going to ask unanimous consent for the Pryor amendment and the Boxer amendment and then ask my amendment be in the next series of votes.

Mr. REID. Mr. President, I reluctantly have to object. I personally

could care less, but until the two managers are here—unless you have cleared it with the two managers.

Mrs. HUTCHISON. No, I have not.

The PRESIDING OFFICER. The objection is heard.

The Senator from Texas has requested the yeas and nays. Is there a sufficient second? There is a sufficient second. The yeas and nays are ordered.

Mrs. HUTCHISON. I ask unanimous consent following the vote this afternoon in relation to the Dodd amendment No. 969, the Senate vote consecutively in relation to the following amendments: Pryor amendment 981, Boxer amendment 1001; provided further that there be 2 minutes equally divided between each of the votes with no amendments in order to the amendments prior to the vote.

Mr. REID. We do not object.

Mrs. HUTCHISON. And I ask the Democratic leader work with me to be in the next series of votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I say to the distinguished Senator from Texas we will try to do that. It seems the right thing to do.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 969

The PRESIDING OFFICER. Under the previous order, the hour of 2:15 having arrived, there will now be 10 minutes evenly divided prior to a vote in relation to the Dodd amendment, No. 969.

Mr. DODD. Mr. President, do I need to ask unanimous consent the present amendment be temporarily set aside?

The PRESIDING OFFICER. That is unnecessary.

Mr. DODD. Mr. President, in the 5 minutes I have, let me discuss it very briefly with my colleagues.

This amendment would allow Medicare beneficiaries the freedom to move between plans for the first 2 years that this benefit is in effect, from 2006 to 2007. Under the present bill, you have to make a decision immediately and then you are locked into that decision for a year. Then you would have an open enrollment period for a month after that, and then you would be locked in for another year.

What we are offering with this amendment is initially seniors be given a 2-year window in order to decide which plan works best for them. Then you would go to the 1 year with the 1-month open enrollment. But, initially, given the tremendous amount of potential confusion about which of these various alternatives would work best for people, they ought to be given a bit more time than to have to make an almost instantaneous decision about which of these plans is best suited for them.

One of the hallmarks that has been used to describe this bill is it is to give people choice—flexibility and choice. All we are suggesting is an additional 2 years, if you will, not requiring an immediate decision but a 2-year window in order to make that choice so people are more well informed.

There are a number of areas in the underlying bill that do not go nearly far enough, in my view, to serve Medicare beneficiaries. But I believe this is a good first step, at least as presently proposed. I am inclined to be supportive of this bill. These are some small points I think could help make this a better bill.

If enacted, the underlying bill would require, as I mentioned, Medicare beneficiaries to choose a prescription drug plan and to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes in the Medicare Program, I am fearful many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. Beneficiaries would be faced with a menu of plans offering varying premiums, copayments or coinsurance, drug formularies, and all the other variables that make up a prescription drug benefit. It may not be immediately clear to people over the age of 65 which of these plans is going to best suit their needs. It is not difficult to imagine a scenario where this could become a significant problem, possibly even affecting the health and well-being of the beneficiary we are trying to assist with this legislation.

A senior on a tight budget might enroll in a plan in an area that offers slightly lower premiums and coinsurance. Perhaps that beneficiary is on blood pressure medication and, after enrolling in the plan, discovers the particular medication—which she has been taking for years and has proven to be effective for a condition, with minimal side effects—is not part of the formulary for the plan she chose immediately.

What I am suggesting is, What are her options? As the bill is currently written, she is stuck with that plan for at least a year. So she can try to navigate the hurdles and obstacles that would allow her to take an off-formulary drug, or switch to another drug that might not be as effective or cause severe side effects. These are not optimal choices.

One of our stated goals is to give seniors as much of a choice as possible, and I am firmly behind that goal, as I mentioned at the outset of these remarks.

I do not want to suggest for a second that we should reduce choice or create simplicity, nor do I question the importance of cost-control mechanisms such as formularies. However, with choice and differentiation comes uncertainty. I believe we can greatly relieve this uncertainty by allowing those initially choosing prescription drug plans for the very first time the opportunity to move from one plan to another to determine which of these plans offers the best plan to fit their needs, and to give them the opportunity of doing that for a 2-year period, and then go to the open enrollment period and a 1-year after that.

I asked people in my own State to take a look at this proposal. In fact, this language comes from them. Their suggestion is this language I have on this chart. I will read from it:

> The amendment which you are proposing is essential to ensure fair and informed access to the health plans which are planned under the terms of S. 1.

By the way, these people are very much supportive of what Senator GRASSLEY is doing in this bill. They say:

> Our experience with Medicare beneficiaries in Connecticut and nationally has shown that the ability of a Medicare beneficiary to change from plan to plan, especially during the period after initially choosing a plan, is of utmost importance. Making choices about which health plan is best is often confusing for a Medicare beneficiary, especially for those who are elderly, frail or having medical problems. Comparing plans and choosing the right plan can be a complicated process, and Medicare beneficiaries who discover they have not made the most informed choice, whose experience with a plan demonstrates it is not adequate to meet their needs, or who have changes in their life circumstances, need to have some ability to change from one plan to another. Only with this ability to change can they be assured the opportunity to receive the kind of health care they want, and the fullest health benefit they need, to meet their individual circumstances under the Medicare program.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 30 additional seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. All we are asking is, instead of forcing people to make that initial decision, they be given that 2-year window to sort this out. And then you move into the 1 year and the window opens, and so forth. I do not think this has any significant financial implications. It is just allowing people to make intelligent, good choices which all of us want to provide people, particularly older Americans who could be terribly confused by choosing formularies and coinsurance and copayment plans. All that has to be done at the outset once this bill becomes law.

I have used a little more time than I said I would to try to explain the amendment, but I want it to be clear to my colleagues why I think this is a